STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010078	A. BUILDING: _____ B. WING _____	10/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDMILL NURSING PAVILION	16000 SOUTH WABASH SOUTH HOLLAND, IL 60473

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S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.1010h)
300.1010i)
300.1210b)
300.1210d)3)
300.1620a)
300.3240a)

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)

i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. (B)

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a

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S9999	Continued From page 2 resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observation, interview and record review facility failed to perform comprehensive pain assessments on (R1, R10, R11 and R21). Facility failed to implement a pain management plan of care for R1 on hospice care.This failure resulted in R1 experiencing unrelieved break through pain. The facility also failed to assess and monitor (R25) for an acute change of condition. This applies to 4 of 15 residents (R1, R11, R10 and R21) reviewed for pain management in the sample of 24 The Findings include; 1) On 9/29/2015 at 10:00AM, R1 was observed in bed with facial grimacing and complaining of severe pain. E12 (nurse), was present at R1's bedside during this observation. E12 stated R1's pain was probably due to wound treatments and dressing changes done early that morning. E12 told R1 "you got Tylenol and your not due for the morphine until 2:00PM (4 hours from now)." E12 then walked out of R1's room and proceeded with caring for other residents. R1 observed with bilateral hands contracted into fists and bilateral inner knees pressing against each other without protective padding between and with dressings in place. On 9/29/2015 at 10:10AM, E12 stated R1 is on hospice care and receives scheduled Morphine 5	S9999		

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S9999	Continued From page 3	S9999		

mg (milligram), every eight hours (6AM, 2PM and 10PM), daily and Tylenol extra strength for break through pain.

On 9/29/2015 at 10:25AM, after several inquiries about R1's un-relieved pain, E12 stated "I will call hospice about {R1's} unrelieved pain today."

On 9/29/2015 at 3:10PM, Z2 (R1's hospice nurse), stated R1 was assessed 9/29/2015 to have break through pain. Z2 said R1's plan of care include physician orders to receive morphine 5mg every two hours as needed (PRN), for break through pain in-between the scheduled every eight hour dose. Z2 stated E12 told Z2, he was not aware of R1's PRN morphine order, so E12 administered Tylenol for break through pain. Z2 said R1's scheduled morphine will be increased from 5mg to 7.5mg starting 9/29/2015.

On 9/30/2015 at 9:30AM, R1 observed in bed. R1 stated she was not in any pain right now.

R1 has diagnosis including osteoarthritis, cervical myelopathy (compression of spinal cord in the neck), quadriplegic and dementia. R1 has a stage 4 infected large sacral pressure ulcer acquired at facility 5/11/2015. R1's hospice records include R1 was placed on hospice care 8/21/2015.

R1's 9/14/2015 physician orders include morphine 5mg every two hours PRN for break through pain.

R1's September 2015 medication administration record (MAR), lists the PRN morphine order but never administered 9/14 through 9/29/2015 11:59AM. First dose administered was 9/29/2015 at 12:00PM for low back pain at a pain rating of 9 out of 10.

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S9999	Continued From page 4	S9999		

R1's current care plan include problem : alteration for comfort due to moderate joint pain with diagnosis of osteoarthritis and rheumatoid arthritis. Interventions include medicate as ordered.

R1's hospice care plan include to medicate for pain as indicated, notify physician if pain medications are ineffective in controlling signs and symptoms of pain.

R1's wound and pressure ulcer flow records include:

- 9/29/2015 sacral pressure ulcer stage 4, 4.3 cm (centimeters) x 4.8cm x 3.2cm with undermining 6.8cm at 12:00 o ' clock. 100% loose gray yellow slough, moderate to heavy amount of drainage and dark, discolored tissue on peri-wound (area surrounding wound).
This wound acquired at facility 5/11/2015.

- 9/22/2015 acquired left medial knee fluid filled blister 1.5cm x 2.0cm

- 9/29/2015 acquired right medial knee fluid filled blister 2cm x 1.5cm.

R1's 9/22/2015 wound physician progress note include presence of ischemic wounds on left foot first and second toes and one on the right foot first web space.

R1's 9/02/2014 "comprehensive pain review" does not indicate site or non-verbal pain indicators presented.

R1's last pain review 7/17/2015 only documents R1 continues to complain of pain, not relieved

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S9999	Continued From page 5	S9999		

with current regimen. Medications changed to help control pain.

No further pain assessment completed after the 7/17/2015 review to present (9/29/2015).

During a 10/01/2015 4:55 PM telephone interview, Z3 (R1's physician), stated R1's pain is probably related to her wounds.

2) R11 admitted to facility 01/21/2015. R1's medical records failed to include a comprehensive pain assessment.

R11's 7/28/2015 minimum data set assessment (MDS), describes R11 unable to verbally communicate and severely cognitively impaired.

R11's physician orders include Tylenol 640mg every 6 hours PRN pain.

R21 has multiple medical diagnoses including Cancer of the breast, Stage 4. R21 has been identified by the facility as having pain issues according to the CMS 802 Matrix provided by the facility. R21 is on a scheduled pain medication (Tramadol 50 mg BID-twice daily).

R21's POS (Physician's Order Sheet) from June 2015 contains an order dated 6/2/15 to increase R21's Tramadol to 50 mg orally twice a day. Prior to that, R21 was receiving Tramadol 25 mg twice a day, per Controlled Medication Prescription form dated 5/19/15.

On 10/2/15 at 1:10 pm, E20 (Treatment Nurse) stated she obtained the order to increase R21's pain medication due to R21's complaints of breast pain, primarily on the evening or night

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S9999	Continued From page 6	S9999		

shifts; she received this report from nursing staff on those shifts. R21 has breast cancer with a wound of her breast which requires treatment. Although R21 did not complain of pain during wound care, E20 stated because she did complain of breast pain at times, she thought her pain medication should be increased.

R21's clinical record does not contain an initial comprehensive pain assessment. It does contain quarterly pain reviews from 12/13/14 through 7/24/15 . This pain review form only contains the space for the date and some blank lines where the author can write in whatever information they see fit. Although entitled Quarterly Comprehensive Pain Review, this is not a comprehensive evaluation. R21's quarterly assessments all contain a handwritten note indicating that R21 has no pain at the time of the assessment, . It does not assess the need for R21's scheduled pain medicine, nor does it address the level of pain when R21 does have pain. It does not address the need for the increase in R21's pain medication.

R21's admission date was 7/23/14. R21's clinical record does contain a pain questionnaire date 7/23/14. At that time, R21 was scored a "3", which indicated no need for a comprehensive pain assessment. This assessment indicated routine medication for pain not ordered. The back of this form, entitled Comprehensive Pain Review, is blank. There was no Comprehensive Pain Review done for R21, either when her pain medication was originally ordered, nor when it was increased in June 2015 due to complaints of pain.

Facility policy entitled 'Pain Screening and Management" states , "5. Conduct a

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S9999	Continued From page 7	S9999		

comprehensive pain screening upon admission to the facility, at the quarterly review, whenever there is a significant change in condition and when there is a consent of new pain or worsening of existing pain". This was not done for R21.

Per R10's demographics, R10 is a 94 year old resident with multiple medical diagnoses including Degenerative Joint Disease (DJD), Arthritis and Chronic Back Pain.

On 9/30/15 E16 (Nurse) gave R10 2 tablets of Acetaminophen 325 mg (650 milligrams) for pain at 10:10 AM and at 2:20 PM. E16 did not assess R10's pain (did not ask location, intensity, severity and type) prior to giving the pain medication.

On 10/1/15 around 10:30 AM to 11:00 AM R10 stated, " The pain medication they (staff) gave me does not work well. I am always in pain, I told them (staff) it doesn't work with me but I guess that's the only pain reliever they can give me."

The Face Sheet documents R25 was admitted on 9/16/2015 with the following diagnosis: gastrostomy, rehabilitation, peripheral vascular disease, high blood pressure and chronic kidney disease. The History and Physical Form dated 9/28/2015 states, R25 has a recent acute respiratory failure episode before the nursing home admission. Physician Order dated 9/16/2015 documents R25 was admitted with an order for oxygen 2 liters per nasal cannula when needed and Albuterol Sulfate nebulizer(breathing) treatment every 6 hours for shortness of breath.

On 9/30/2015 at 8:33 AM, E5(Certified Nursing Assistant) brought R25 who was grunting, panting and wheezing into the dinning room. R25 had a portable oxygen tank on the back of the

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S9999	Continued From page 8	S9999		

wheelchair with oxygen infusing via nasal cannula. E5(CNA) placed R25 at a table and asked R25 how are you doing? Before R25 could respond, E5 exited the dining room. R25 said "not too good" remained at the table in respiratory distress. R25 became progressively worse with panting, shallow breaths and grunting, attempted to eat and vomited her meal at the table. On 9/30/2015 at 8:39 AM, E6(CNA) brought R25 to her room and stated "the nurse will be in shortly". While in the room R25 continued to pant, grunt and wheeze while intermittently exchanging slow shallow breaths. R25 gasped and slowly said " I think I am dying." After inquiring about when the nurse would be in to check R25, E6(CNA) went to get the nurse. On 9/30/2015 at 8:40 AM, E10(Nurse) entered the room with E5. E10 assessed R25 and provided a nebulizer(breathing) treatment. E10 said E5(CNA) should have alerted me as soon as R25 experienced respiratory distress.

On 9/30/2015 at 9:10 AM, E10(Nurse) said, R25 did not do well with her breathing treatment and is being sent out to the hospital.

Nursing Progress Note dated 9/30/2015 states, R25 was admitted to the hospital with a diagnosis of pneumonia.

Acute Condition of Changes- Clinical Protocol revised 11/2013 does not address when direct care staff should notify the nurse of a change of condition.

(B)

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WINDMILL NURSING PAVILION	16000 SOUTH WABASH SOUTH HOLLAND, IL 60473

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S9999	Continued From page 9 300.661 Section 300.661 Health Care Worker Background Check. A facility shall comply with the Health Care Background Check Act (225 ILCS 46) and the Health Care Background Check Code (77 Ill. Admin. Code 955). (Source: Amended at 29 Ill. Reg. 12852, effective August 2, 2005). Findings include: Health care worker background check was conducted on 10/1/15 around 1:30 PM to 2:00 PM with E1 (administrator). E17 is a CNA who was hired on 2/17/15, no reference check done prior and after hiring E17. On 10/2/15 at around 2:00 PM E1 stated, she re-checked the files of all the employees discussed with concerns to background check and E17 is the only one with no reference check. Facility's Policy for Background Screening Investigation indicates: Facility conducts employment background checks, reference checks and criminal conviction investigation checks on individuals making application for employment with the facility. Policy Interpretation and Implementation indicates:	S9999		

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S9999	Continued From page 10 The Personnel/Human Resources Director, or other designee, will conduct employment background checks, reference checks and criminal conviction investigation checks on persons making application for employment with the facility. (B)	S9999		